HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE

REPORT TO THE HOUSE OF REPRESENTATIVES

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House Select Committee on the Rising Cost of Health Care

April 15, 2004

To: Speaker James B. Black
Speaker Richard T. Morgan
Members of the North Carolina House of Representatives

Attached is a report from the House Select Committee on the Rising Cost of Health Care submitted to you as directed by the Speakers in their authorizing declaration effective September 12, 2003.

The House Select Committee on the Rising Cost of Health Care presents to you findings and recommendations based on its study. Proposed legislation is contained within this report.

Respectfully submitted,

Representative William T. Owens, Jr.
Co-Chair

Representative Bonner Stiller
Co-Chair

House Select Committee on the Rising Cost of Health Care

Membership List

Rep. William Owens, Jr., Co-Chair

Rep. Bonner Stiller, Co-Chair

Rep. Cary Allred

Rep. Bobby Barbee, Sr.

Rep. Larry Bell

Rep. Curtis Blackwood

Rep. Alice Bordsen

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PREFACE

In a declaration effective September 12, 2003, the Speakers of the House of Representatives charged the House Select Committee on the Rising Cost of Health Care to determine how to stem the rising cost of health care. ***Appendix A.*** The Committee consists of 22 members. Of these members, eleven were appointed by Speaker Black and eleven were appointed by Speaker Morgan.

This report represents the work of the House Select Committee on the Rising Cost of Health Care from its creation until the convening of the 2004 Session of the 2003 General Assembly. The Committee met on eight occasions regarding a variety of topics concerning the rising cost of health care, including current trends in public and private health care costs, factors fueling health care costs both generally and as it relates to specific providers, and various options for addressing increasing health care costs. In addition to eight full Committee meetings, two subcommittees were convened for a total of three meetings to address the issues of disease management and health care workforce shortages.

EXECUTIVE SUMMARY

The cost of providing and paying for health care has been rising at an alarming rate. Nationally, health care spending grew nearly four times faster than the United States economy in 2002. Between 2001 and 2002, health care costs increased, with general inflation accounting for only 18% of that increase. Drugs, medical devices, and medical advances contributed 22% to the increase, not accounting for the potential cost savings that these drugs and devices might have produced. Increased provider expenses contributed 18% to the increase. Government regulation on health care, such as mandated benefits and duplicative federal and state regulations, contributed 15% to the increase. Increased consumer demand contributed 15% to the increase due to the older population and increased attention to prevention of and diagnosis of disease. Litigation related expenses and risk management contributed 7% to the increase, in the form of defensive medicine practices, medical malpractice premiums, and outsized legal awards and costs. Miscellaneous factors, such as fraud and coding errors, contributed 5% to the increase.

While the average length of hospital stay decreased from 6.86 days in 1989 to 4.92 days in 2001, acute care admissions increased 26% between 1989 and 2001. Additionally, prescriptions for heavily advertised drugs increased 25% between 1999 and 2000, while prescriptions for all other drugs increased only 4%. Spending on prescription drugs again increased 13.2% in 2002 after a three-year deceleration.

Many employees buy health insurance for themselves and their families through their employers' group insurance plans. Annual health care costs per employee increased 79% from $3,907 in 1999 to $7,009 in 2004, as compared to increases of 3.5% for automobile insurance, 4% for national defense, 10% for housing, and 9.5% for food. Consequently, employers have experienced insurance rate hikes of 14-15% on the most popular type of health plans. Employers have responded by reducing employer contributions to premiums, increasing deductibles and copays, and moving to defined contribution benefit plans.

State or federal laws currently require insurance companies to provide coverage for over 1,500 specific health services, increasing the cost of insurance plans by an estimated 15-30%. According to the federal General Accounting Office, mandates accounted for up to 22% of average claims costs in Maryland, the state with the most mandates, and 12% of claims in Virginia in 1996. A 2002 study by PriceWaterhouseCoopers revealed that mandates and other government regulation accounted for $10 billion of the $67 billion increase in health premiums between 2001 and 2002.

Growth in the numbers of health care professionals is not keeping up with the increasing demand for health care, and states are experiencing workforce shortages. In North Carolina, 57 counties or parts of counties have been designated as Health Professional Shortage Area Counties for primary medical care, and 60 counties or parts of counties have been designated as Health Professional Shortage Area Counties for dental care.

The Committee undertook the monumental task of determining how to stem the rising cost of health care by hearing from providers, advocacy groups, private citizens, and organizations. What follows is a summary of the Committee's proceedings and its findings and recommendations.

COMMITTEE PROCEEDINGS

November 6, 2003

The House Select Committee on the Rising Cost of Health Care convened on Thursday, November 6, 2003 at 1:00 p.m. in Room 643 of the Legislative Office Building. The purpose of the meeting was to provide an overview of trends in public and private health care costs and factors that contribute to the cost of health care.

After Co-chairs Bill Owens and Bonner Stiller welcomed the committee, Dianna Jessup, Staff Attorney and counsel to the Committee, reviewed the committee's charge. In determining how to stem the rising cost of health care, the committee is charged with considering the economics of health care costs as well as the effects of the costs.

Following Ms. Jessup's overview, Dr. Sandra Greene with the Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill explained current trends in health care costs, cost drivers, employer actions to recent increases, and possibilities of what is to come. She reported that hospital inpatient and outpatient utilization and costs, use of technology (particularly imaging), and prescription drug prices and utilization are increasing. Reasons for these increases include technological advances, new drug development, dismantling of managed care, provider consolidation, consumer demand and expectations, and aging of the population. Employers are reacting to increased health insurance premiums by taking actions such as reducing employer contributions to premiums, increasing deductibles and copays, and moving to defined contribution benefit plans. She concluded that significant health care cost increases will continue to occur.

Deputy Secretary Lanier Cansler from the North Carolina Department of Health and Human Services next spoke on current trends in public health care costs. He explained the impact of the cost of health care related services on the Department's budget and the various factors that are impacting those costs. Health care related services, including Medicaid, currently comprise approximately 25% of the State's budget and 80% of the Department's budget. Factors impacting the public costs of health care include: 1) the State's growing population; 2) increased utilization of services; 3) the cost of care; 4) prevention efforts such as immunizations; and 5) bioterrorism prevention efforts. Costs could be controlled by reducing Medicaid eligibles, services, or provider reimbursements, but the State is mandated by federal law to provide some of the services, and reducing eligibles or reimbursement rates present a difficult choice for legislators.

Finally, Paul Mahoney, Executive Director for the NC Association of Health Plans, Inc. spoke to the Committee about factors driving health insurance premiums and opportunities for controlling health care costs. Trend factors that are increasing premiums include drugs, medical devices and medical advances, rising provider expenses, government mandates and regulation, increased consumer demand, and litigation and risk management. He suggested that supply and demand does not work in health care to control costs because supply creates demand, horizontal integration reduces competition, patients are sheltered from the cost impact of their decisions, and little comparative information on cost or quality is available. According to Mr. Mahoney, moving to evidence-based medicine represents a way to help control costs, as would adjusting payment systems to pay for prevention and good outcomes, not just treatments; providing

consumer incentives for healthier lifestyles; managing chronic diseases better; encouraging "consumer driven" benefit plans; providing relative cost and quality information to empower consumers; looking at mandated benefits to ensure cost efficiency; allowing innovation in health plan design through pilot projects; tort reform to create safe harbors for systemic efforts to reduce medical errors; stronger enforcement of anti-trust laws to promote competition; and streamlining regulatory reporting and data collection.

The meeting concluded with a discussion of future topics for meetings.

December 10, 2003

The House Select Committee on the Rising Cost of Health Care met on Wednesday, December 10, 2003 at 10:30 a.m. in Room 643 of the Legislative Office Building. Topics of this meeting included hospital and pharmacy costs and community health centers.

Hugh Tilson from the NC Hospital Association spoke to the Committee about hospital cost drivers. According to Mr. Tilson, one of the factors that is increasing hospital costs is increased utilization due to a growing, aging population and increased demand for both inpatient services and outpatient care. In addition, the cost of caring for patients is increasing because of increasing personnel costs (due to workforce shortages), better but more expensive technology, liability insurance costs, the cost of caring for the uninsured, and the aging of hospital facilities. Mr. Tilson offered the following suggestions: 1) fund health care professional training; 2) address the professional liability insurance crisis; 3) scrutinize mandated benefits; 4) ensure adequate funding of government health care programs; and 5) strengthen and expand Carolina Access.

Moses Carey from the NC Primary Health Care Association then addressed the cost effectiveness and quality of Community Health Center services. The Association represents 71 centers operated by 20 organizations. Community health centers were established to address health care needs in medically underserved areas. These centers provide health and some dental care and pharmaceutical services, regardless of ability to pay. Patients pay on a sliding scale. The centers are supported by a combination of federal grants, state and local grants, contracts, and funds, foundations and private funds, private third-party payers, and patient fees. Mr. Carey requested a $5 million annual State appropriation to support indigent care, capital improvements, and technology for these centers.

Dr. Mark Gregory, President of the NC Association of Pharmacists concluded the presentations at this meeting with a discussion of rising prescription costs and how those increasing costs relate to community pharmacies. According to Dr. Gregory, the increase in the number of prescriptions, shifts to costlier prescription drugs, and price inflation have all contributed to increased drug costs. He suggested that the State could save significant dollars by mandating the increased use of generic drugs and shifting away from the use of brand name drugs. He also suggested that disease management programs could reduce health care costs. He described one successful disease management program, the Asheville Project. Dr. Gregory stated that over time, direct medical costs of patients in the Asheville Project have been reduced.

The meeting concluded with a discussion of possible actions that could be taken to address Medicaid issues.

January 14, 2004

The House Select Committee on the Rising Cost of Health Care met on Wednesday, January 14, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. During this meeting, the Committee heard from providers concerning rising costs and proposals to slow those costs.

Jeff Peterson from GlaxoSmithKline, Inc. presented information on the role of prescription drug spending in overall health care spending. According to Mr. Peterson, prescription drug spending increased 19% from 2000 to 2001. The majority of that increase resulted from increased demand for and utilization of prescription drugs. Mr. Peterson acknowledged that direct to consumer advertising can create increased consumer demand for a drug because the advertising is aimed at educating the public, but asserted that there is no correlation between the advertising and price increases. He stated that prescription drugs do provide value because they can help prevent and cure disease, contribute to increased life expectancy, cut death rates for chronic and acute conditions, improve overall health and quality of life, keep employees on the job and productive, and reduce total healthcare costs, eliminating the need for more costly interventions.

Next, Dr. Lawrence Cutchin, President of the NC Medical Society, addressed the Committee. He discussed some of the factors contributing to increasing health care costs, including decreased competition among health insurers, increasing medical liability insurance premiums, and poor lifestyle choices. He made the following suggestions: 1) Reject provider reimbursement reductions and instead get physicians actively involved by providing them with useful feedback on their actual performance as it compares to desired performance. This will require committing resources to information systems that can collect and analyze data to generate comparative information reports back to physicians and other providers. 2) Employ data systems to identify and reward those who are doing the right things with the right results, rather than punishing all with fee cuts. 3) Commit more resources to educate and motivate patients to employ healthy lifestyle modifications. 4) Commit resources to educate and motivate patients regarding the appropriate consumption of health care resources. 5) Expand Carolina Access III and commit resources to support the work of the Physician Advisory Group. 6) Restore a competitive payor environment by addressing legislative and regulatory issues that make it unattractive and unprofitable for small group insurers to do business in our State. 7) Pass medical liability reform legislation. 8) Commit resources to assure the continued viability of primary care practice.

The final speaker for this meeting was Tim Rogers, Executive Director of the Association for Home and Hospice Care of NC. He spoke to the Committee about Home and Hospice Care and how this care can help lower the cost of health care. According to Mr. Rogers, home care allows patients to live at and receive services in the home and can prevent or shorten the length of time that would otherwise be needed for more expensive care such as hospital inpatient or nursing home care. He recommended that the General Assembly place a higher priority on funding home care services in the Medicaid program; explore ways to allow DHHS the flexibility to transfer funds from institutional services to home care services when the patient chooses home care and when home care can be a cost effective setting; and ensure that the Medicaid program requirements do not increase provider costs and remove requirements that do not add value to the program, such as requiring a physician signature for an aide care plan.

Before adjourning, the Committee discussed possible topics for the next meeting, along with an overall schedule that would permit the Committee to complete its work by the April 15, 2004 reporting deadline.

February 4, 2004

The House Select Committee on the Rising Cost of Health Care met on Wednesday, February 4, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. During this meeting, the Committee heard presentations about home health care, disease management programs, health savings accounts, health care costs from the consumer's perspective, kidney dialysis and end stage renal disease treatment, health care costs and the uninsured, and ways to improve the ability of small business owners to afford health insurance.

Phil Driver, a constituent of Rep. Bordsen, was recognized to discuss his experience with home health care. He expressed real concern about possible budget cuts to Medicaid and Medicare. He related his experience with living in an assisted living facility as compared to living at home. He felt very strongly that being able to live at home was less expensive and allowed him to contribute to his community.

Next, Barry Bunting, Clinical Manager of Pharmacy Services, Mission St. Josephs Hospital was recognized to discuss the Asheville Project. The Asheville Project is a demonstration project being undertaken by the City of Asheville in conjunction with Mission St. Josephs and pharmacists to offer a disease management program for the City's employees with diabetes, asthma, hypertension and high cholesterol. He said that in order for a disease management program to be successful, there has to be intense patient self-care education up front with adequate financial incentives to encourage the patient's participation. There also needs to be frequent follow-up by knowledgeable, accessible health care providers (pharmacists/educators). Participation in the Project has resulted in an average net savings of $2,033 per person with diabetes and nearly 50% reduction in sick days. His recommendations were: 1) focus on preventing avoidable ER/hospital admissions, 2) consider an "Asheville-like" model for state employees with diabetes and asthma and 3) consider potential incentives for Medicaid patients with high-risk illnesses to participate in wellness programs that have proven benefits.

Adam Searing, Project Director for the NC Justice Center's Health Access Coalition was recognized for his comments. His recommendations included controlling rising prescription drug costs by taking actions such as investigating bulk drug purchasing, using prevention strategies to control long-term health costs such as addressing the issue of obesity, increasing the cigarette tax, tapping the large economic benefits of helping the uninsured purchase affordable health insurance and reducing the use of unnecessary diagnostic tests and procedures as has been experienced in the Carolina Access program. He felt that medical malpractice reform would be unlikely to have a substantial effect on controlling the costs.

The Chair then recognized Tom Gill with DaVita, Inc to discuss kidney dialysis and end stage renal disease. DaVita is one of the largest providers of dialysis services to people with kidney failure. DiVita operates 131 centers in North Carolina, caring for over 2,500 patients. With adequate care, patients require fewer hospitalizations and fewer drugs. He recommended ensuring continued or increased Medicaid reimbursement for dialysis.

Joan Garner, Executive Director, State Services, Blue Cross and Blue Shield was recognized to speak about health care costs and the uninsured. Ms. Garner said that hospital and physician

services account for almost one third of private health spending. According to the Census Bureau Survey, there are over 41 million uninsured. The key segments of the uninsured population are persons with annual household incomes greater than $50,000, and Medicaid and SCHIP eligbles. Young adults are twice as likely to be uninsured as older people. Her recommendations included: 1) supporting State and federal initiatives that ensure adequate funding and encourage cost-effective behavior; 2) sharing information about programs that improve access to quality care and encourage health behavior; 3) promoting evidence-based medicine, providing information to make better individual health care decisions and to prevent fraud; and 4) using analyses of health care cost drivers to educate and promote understanding and change.

Robert Paschal representing NC Association of Health Underwriters, American Association of Health Plans, Health Insurance Association of America, Health Savings Accounts and Health Insurance Costs was recognized to discuss Health Savings Accounts (HSA5) to help individuals save for qualified medical and retiree health expenses on a tax-free basis. He recommended conforming the North Carolina tax codes to the federal tax code to permit these accounts.

The final speaker for the meeting was Ches Gwinn with Metrolina Health Initiative (MHI). Mr. Gwinn discussed a partnership approach to lowering health care costs and improving the ability of small employers to afford health insurance. He felt that the solution rests on a two-fold approach: 1) improve access to insurance for small businesses which employ 60% of the workforce in North Carolina and 2) reduce the volume of the most frequent and highest cost illnesses. His recommendation would be to establish a "North Carolina Health Care Reform Commission" to address these issues. The Commission would be composed of a representative group of stakeholders similar to the MHI's Board. It would be charged with developing potential regulatory change to support lowers premiums, test regulatory reform in related geographic areas, sub-contract with the State and other entities to manage pilots, perform data collection and analysis and implement small group regulation reform and targeted education and cost management program which achieved success in pilots.

The Committee adjourned to reconvene on February 18 to begin discussing proposals and possible legislative recommendations. Due to inclement weather on February 18, the next meeting of the Committee was March 3, 2004.

March 3, 2004

The House Select Committee on the Rising Cost of Health Care met on March 3, 2004 at 10:00 a.m. in Room 1124 of the Legislative Building. During this meeting, the Committee discussed the proposals that speakers had presented to the Committee and began to narrow the topics for possible legislative recommendations. The Committee decided to meet again on March 16, 2004 to discuss possible legislative recommendations further. To facilitate the Committee's work, the chairs appointed two subcommittees to study and report to the full Committee as to proposals to address healthcare workforce shortages and concerning disease management. Appointed to the health care workforce subcommittee were Rep. Tolson, Chair; Rep. Wright, Rep. Jeffus, and Rep. Goforth. Appointed to the disease management subcommittee were Rep. Nye, chair; Rep. Sherrill, and Rep. Howard.

March 10, 2004 – Subcommittee on Health Care Workforce Issues

The subcommittee appointed by the chairs to address health care workforce issues met on March 10, 2004 at 3:00 p.m. in Room 414 of the Legislative Office Building. Rep. Tolson, chair of the subcommittee, welcomed those present and offered his comments concerning the task before the subcommittee. The subcommittee heard from Torlen Wade from the Office of Research, Demonstrations and Rural Health Development, Department of Health and Human Services, concerning efforts to recruit physicians and dentists to work in underserved areas of the State. Mr. Wade stated that 57 counties or parts of counties have been designated as Health Professional Shortage Area Counties for primary medical care, and 60 counties or parts of counties have been designated as Health Professional Shortage Area Counties for dental care. The Office of Research, Demonstrations and Rural Health Development provides comprehensive recruitment assistance to communities and practices that serve underserved residents. Key elements of this assistance include recruitment of providers and offering incentives such as loan repayment or service bonuses to providers.

The subcommittee also heard from Hugh Tilson from the North Carolina Hospital Association, who expressed his organization's concern about a shortage of health care workers available to provide care, including nurses, radiology technicians, and medical technicians. He also said there is a need to develop capacity to train people to provide care. It was noted that the Institute of Medicine is currently studying the nursing shortage and is expected to have a report soon.

The subcommittee discussed what could be done in the short period of time left for the committee and decided that the issue deserved further study but in the meantime, community colleges and universities should be encouraged to make development of workers available to provide care a priority.

March 11, 2004 and March 16, 2004 – Subcommittee on Disease Management Issues

The subcommittee appointed by the chairs to address disease management issues met on March 11, 2004 and March 16, 2004. On March 11, the subcommittee met at 1:00 p.m. in Room 421 of the Legislative Office Building and heard from Blue Cross, Blue Shield (Dr. Doug Knoop), Cigna (Dr. Scott Josephs), Community Care of North Carolina (Dr. Laura Gerald), and the State Employees and Teacher Major Medical Plan (State Health Plan) (Lisa Bultman) concerning the various disease management efforts being undertaken. In disease management programs, patients who have certain high cost health conditions are identified and various strategies are undertaken to better manage the care of those patients, including educating the patients on self-care, providing incentives to encourage better self-care, following evidence-based care strategies, and establishing coordinated care interventions.

In the case of the State Health Plan, disease management efforts are relatively new. The State Health Plan has disease manage programs for end stage renal disease, pediatric asthma, diabetes and coronary artery disease. All of these programs have been underway for less than three years. Results presented by Ms. Bultman concerning the pediatric asthma program alone indicate a total program savings of $261,144 in the first year of the program and $318,178 in the second year.

According to Dr. Gerald, the primary goal of Community Care of North Carolina is to improve the care of the State's Medicaid population while controlling costs. Current disease management

initiatives being undertaken include programs for asthma and diabetes. Pilot programs are being undertaken for depression, ADHD, special needs children, gastroenteritis, otitis media, and low birth weight. Findings from the Sheps Center show a CY2002 savings of $1,580,000 in the asthma program and a three year cost savings for diabetes care of approximately $2.1 million. The Sheps findings also indicate there could have been a potential savings of more than $11.3 million in 2003 had Community Care been implemented statewide for asthma and diabetes disease management.

On March 16, the subcommittee met at 8:30 a.m. in Room 612 of the Legislative Office Building, and Rep. Nye, chair of the subcommittee, presented a number of recommendations for the subcommittee's consideration. The subcommittee adopted a slate of recommendations for presentation to the full committee.

March 16, 2004

The House Select Committee on the Rising Cost of Health Care met following the disease management subcommittee on March 16 in Room 643 of the Legislative Office Building. During this meeting, the committee discussed and adopted the recommendations of the subcommittees on health care workforce issues and disease management. Members discussed other topics in which they were interested. The members submitted their written suggestions for legislative recommendations to the chairs.

March 17, 2004

The House Select Committee on the Rising Cost of Health Care met on March 17, 2004 in Room 544 of the Legislative Office Building at 1:00 p.m. and considered and adopted the findings and recommendations, which appear in this report. Staff was directed to draft legislation and a report for submission to the members.

April 14, 2004

The House Select Committee on the Rising Cost of Health Care convened its final meeting on April 14, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. During this meeting, the committee discussed and adopted the report.

COMMITTEE FINDINGS AND RECOMMENDATIONS

Based on the information presented during the course of its study, the House Select Committee on the Rising Cost of Health Care makes the following findings and recommendations. Drafts of the proposed legislation referenced below may be found in ***Appendix B***.

A. Disease Management

The Committee finds that disease management programs improve health care outcomes and reduce costs by identifying patients with certain high cost chronic conditions, educating those patients on how to better manage their health, improving provider awareness and adherence to evidence-based care strategies, and establishing coordinated care interventions and follow-up systems to prevent unnecessary and more expensive health complications.

Recommendations:

1. The General Assembly should appropriate funds for statewide expansion of Community Care of North Carolina, the managed care program in Medicaid that has a disease management component. ***See Bill Draft 2003-SPz-5 and fiscal analysis***
2. The General Assembly should direct the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan) to aggressively continue efforts to manage disease, claims, and high risk members of the State Health Plan and to develop a program to publicize and promote disease management programs.
3. The General Assembly should direct the Executive Administrator of the State Health Plan to develop an incentives package to encourage participation in disease management programs, including:
    - Offering extra benefits to participants.
    - Offering incentives to providers with case management fees or extra payments.
    - Rewarding providers who meet nationally recognized quality of care guidelines.
4. The General Assembly should direct the Executive Administrator of the State Health Plan and the Department of Health and Human Services to ensure that its disease management programs include adequate technological capabilities that will identify high-cost patients, manage comorbidities, and increase communication between patients and providers.
5. The General Assembly should direct the Executive Administrator of the State Health Plan to publish performance measures that are linked to standardized health status indicators and use the performance measures to justify enhanced reimbursements to providers, targeting State resources for expansion, etc.
6. The General Assembly should direct the Division of Medical Assistance, and the Executive Administrator of State Health Plan to adopt contractual agreements with providers that reward/mandate evidence-based practice standards and guidelines for Medicaid/NC Health Choice for Children and the State Health Plan.
7. The General Assembly should direct the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to ensure collaboration between LMEs and

Community Care of North Carolina providers serving Medicaid enrollees with depression and to require evidence-based practices for the treatment of psychotic illnesses.

8. The General Assembly should encourage the Secretary of the Department of Health and Human Services to consider developing a program of supplemental rebates for improvements to the Medicaid program.
9. The General Assembly should encourage the Division of Medical Assistance to consider the following as it develops plans to improve the quality, utilization and cost-effectiveness of the Medicaid program:
    - Developing new disease management initiatives that target such costly diseases or conditions such as congestive heart failure, chronic lung disease, chronic kidney disease, sickle cell disease and low birth weight.
    - Work in concert with the Division of Public Health and other community organizations to improve the coordination and implementation of key preventive initiatives in obesity, prematurity and smoking cessation.
    - Work with the mental health system (LME's) to develop local systems and processes to enhance the ability of primary care physicians to care for non-targeted mental health and substance abuse patients.
    - Use case management processes to help improve the utilization and access to such community-based services as ancillary and in-home support services.
    - Investigate the use of incentives and/or technology to promote the effective use of evidence-based guidelines by program participants.

See Bill Drafts 2003-LNz-138 and 2003-LNz-141

10. The Committee applauds the efforts of insurers, private businesses, public entities and health care providers in partnering together to create disease management programs and encourage other public and private entities to consider undertaking similar programs.

B. Health Plan Design

The Committee finds that a crisis exists in the availability and affordability of adequate health insurance coverage for individuals and for small business owners and their employees in this State.

Recommendations:

1. The General Assembly should establish a North Carolina Health Insurance Innovations Commission to study this issue in depth and report its findings to the 2005 General Assembly. ***See Bill Draft 2003-LNz-134***
2. The General Assembly should authorize a study of the feasibility of establishing high-risk health insurance pools to enable individuals who have been denied health insurance coverage due to a high-risk or preexisting health condition to purchase coverage at an affordable premium. ***See Bill Draft 2003-LNz-137***

C. Health Savings Accounts

The Committee finds that Health Savings Accounts (HSA5) help individuals save for certain medical and retiree health expenses on a tax-free basis and should be encouraged.

Recommendation:

1. The General Assembly should update the reference to the Internal Revenue Code to include health savings accounts in the State's tax code. ***See Bill Draft 2003-LYxz-135***

D. Health Care Worker Shortages

The Committee finds that health care worker shortages increase provider costs and the overall cost of health care.

Recommendations:

1. The General Assembly should establish a study committee that brings interested and affected parties together to determine how to improve the number of people available to provide care.
2. The General Assembly should encourage the Board of Community Colleges and the Board of Governors to make healthcare workforce development a priority.
   See Bill Draft 2003-SWz-28

E. Insurance Mandates

The Committee finds that while health insurance mandates may improve patient care and that mandated preventative services might save money through early detection of diseases, some mandated services might not be cost effective and may make health insurance disproportionately more expensive for small businesses.

Recommendations:

1. The General Assembly should authorize the Legislative Research Commission to study the issue of health insurance mandated benefits and the cost to employers and individuals of unfunded health insurance mandates.
2. The General Assembly should extend the moratorium on mandates established in S.L. 2001-453 from July 1, 2005 to July 1, 2006.
   See Bill Draft 2003-LNz-139

F. Medical Malpractice Reform

The Committee finds that to the extent medical malpractice costs and awards are causing health care costs to increase, reform should be undertaken.

Recommendation:

1. The General Assembly should undertake reform where it finds that medical malpractice costs are causing health care costs to increase.

G. Childhood Obesity

The Committee finds that overweight children are at risk for developing cardiovascular disease and diabetes, and treating obesity creates a preventable economic burden to the State's health care system.

Recommendation:

1. The Committee supports statewide initiatives and policy changes that promote healthy nutrition and physical activity in children and encourages collaboration among the many agencies and public and private partners involved in these endeavors.

H. Increasing Access to More Cost Efficient Health Care

The Committee finds that community health centers, public health departments, and free clinics increase access to health care for the citizens of this State and provide an alternative to more expensive health care.

Recommendation:

1. The General Assembly should investigate appropriating funds to the Office of Research, Demonstrations, and Rural Health Development, Department of Health and Human Services to award grants to community health centers, public health departments, free clinics and other health care facilities that provide access for indigent patients to more cost efficient health care.

I. Long Term Care Insurance Tax Credit

The Committee finds that the use of long term care insurance to pay for nursing home costs and home health costs has the potential to reduce State Medicaid expenditures by decreasing the number of persons who are forced to rely on Medicaid to pay for these costs, and therefore the purchase of long term care insurance should be encouraged.

Recommendation:

1. The General Assembly should repeal the January 1, 2004 sunset on the long term care insurance tax credit. ***See Bill Draft 2003-SWz-30***

J. Medicaid

The Committee finds that the cost of health care related services, including Medicaid, currently comprise approximately 25% of the State's budget and 80% of the Department's budget and should be examined for cost efficiency.

Recommendations:

1. The Committee urges the Blue Ribbon Commission on Medicaid Reform to consider supporting funding of home care services as an alternative to institutional care.
2. The Committee urges the Blue Ribbon Commission on Medicaid Reform to review current provider requirements in Medicaid to ensure that the requirements do not unnecessarily increase provider costs without adding value to the program.

APPENDIX A

James B. Black
Speaker

Richard T. Morgan
Speaker

Office of the Speaker
North Carolina House of Representatives
Raleigh, North Carolina 27601-1096

TO THE HONORABLE MEMBERS OF THE
NORTH CAROLINA HOUSE OF REPRESENTATIVES

WHEREAS, the cost of providing and paying for health care has been rising at an alarming rate; and

WHEREAS, the costs for private sector health plans also are rising rapidly, causing concern among employers and forcing some to reduce or drop coverage all together; and

WHEREAS, the citizens of this State, particularly the poor and the elderly, are negatively impacted by the rising cost of health care;

NOW, THEREFORE:

Section 1. The **House Select Committee on the Rising Cost of Health Care** is established by the Speakers, effective September 12, 2003, as a select committee of the House pursuant to G.S. 120-19.6(a) and Rule 26(a) of the Rules of the House of Representatives of the 2003 General Assembly.

Section 2. The Select Committee consists of 22 members. The individuals listed below are appointed as members of the Select Committee. Members serve at the pleasure of the Speakers of the House of Representatives.

1) Representative William Owens, Jr., Co-Chair
2) Representative Bonner Stiller, Co-Chair
3) Representative Cary Allred
4) Representative Bobby Barbee, Sr.
5) Representative Larry Bell
6) Representative Curtis Blackwood
7) Representative Alice Bordsen
8) Representative Joanne Bowie
9) Representative Debbie Clary
10) Representative Beverly Earle
11) Representative Bobby England
12) Representative Bruce Goforth
13) Representative Robert Grady
14) Representative Julia Howard
15) Representative Verla Insko
16) Representative Margaret Jeffus
17) Representative Carolyn Justus
18) Representative Edd Nye
19) Representative Wilma Sherrill
20) Representative Joe Tolson
21) Representative Constance Wilson
22) Representative Thomas Wright

Section 3. The Select Committee may meet during the interim period between regular sessions upon the call of its cochairs.

Section 4. The Select Committee shall review the following to determine how to stem the rising cost of health care:

1. The rate at which the cost of health care has been increasing and the reasons for the increases.
2. Actions other states are undertaking to address rising health care costs.
3. The effect of the cost of health care on the availability of health care.
4. The affordability of health care to North Carolinians.
5. The effect of increased costs on the ability of employers to provide health care benefits to their employees.
6. Ways to alter the structure and operation of the health care system to reduce the cost of health care.
7. Factors that affect the cost of health care to citizens and providers and how those factors can be changed to reduce the cost of health care.
8. Any other issues the Select Committee determines is appropriate in addressing the issue of the rising cost of health care.

In undertaking this study, the Select Committee shall review the work of and consider the findings and recommendations of the Blue Ribbon Commission on Medicaid Reform established pursuant to S.L. 2003-284, Sec. 6.14A and the House Blue Ribbon Task Force on Medical Malpractice that relate to the cost of health care.

Section 5. The Select Committee shall report on the results of its study, including any proposed legislation, to the members of the House of Representatives on or before April 15, 2004, by filing one or more reports with the Speakers' offices, the House Principal Clerk, and the Legislative Library. The Select Committee terminates on April 15, 2004 or upon the filing of its final report, whichever occurs first.

Section 6. The Select Committee is vested with the authority contained in Article 5A of Chapter 120 of the General Statutes.

Section 7. Members of the Select Committee shall receive per diem, subsistence, and travel allowance at the rate established in G.S. 120-3.1.

Section 8. The expenses of the Select Committee shall be paid upon the written approval of the Speaker pursuant to G.S. 120-35 from funds available to the House of Representatives for its operations.

James B. Black, Speaker

Richard T. Morgan, Speaker

APPENDIX B

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **D**

BILL DRAFT 2003-SPz-5 [v.7] (4/14)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/4/2004 9:38:11 AM

Short Title:	Community Care of North Carolina Funds.	(Public)
Sponsors:	Representative Nye.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO EXPAND COMMUNITY CARE OF NORTH CAROLINA, THE MANAGED CARE PROGRAM IN MEDICAID THAT HAS A DISEASE MANAGEMENT COMPONENT, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, the sum of three million one hundred eight thousand dollars ($3,108,000) for the 2004-2005 fiscal year to expand Community Care of North Carolina and draw down federal and local matching funds. It is estimated that these expansion funds when matched with federal and local funds will expand Community Care of North Carolina by approximately ten million dollars ($10,000,000).

SECTION 2. This act becomes effective July 1, 2004.

FISCAL ANALYSIS MEMORANDUM

[This confidential fiscal memorandum is a fiscal analysis of a draft bill, amendment, committee substitute, or conference committee report that has not been formally introduced or adopted on the chamber floor or in committee. This is not an official fiscal note. If upon introduction of the bill you determine that a formal fiscal note is needed, please make a fiscal note request to the Fiscal Research Division, and one will be provided under the rules of the House and the Senate.]

DATE: May 4, 2004

TO: **House Committee on the Rising Cost of Health Care**

FROM: Carol Shaw
Fiscal Research Division

RE: 2003-SPz-5 [v.7] – Community Cares of North Carolina Funds

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FISCAL IMPACT

Yes (X) **No ( )** **No Estimate Available ( )**

	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09
EXPENDITURES:					
State	**$3,108,000**	**$2,870,737**	**$2,941,790**	**$3,011,661**	**$3,082,205**
County	**$548,000**	**$507,090**	**$518,642**	**$531,245**	**$543,976**
Federal	**$6,344,000**	**$5,858,778**	**$5,935,255**	**$6,011,856**	**$6,087,670**
Total Expenditures	**$10,000,000**	**$9,236,604**	**$9,395,687**	**$9,554,762**	**$9,713,850**
POSITIONS:	0	0	0	0	0

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED:

Division of Medical Assistance of the Department of Health and Human Services

EFFECTIVE DATE: July 1, 2004

BILL SUMMARY:

The proposed legislation appropriates $3,108,000 from the General Fund to the Department of Health and Human Services to expand the Community Care of North Carolina program and to draw down federal and local matching funds.

ASSUMPTIONS AND METHODOLOGY:

A. Population Served by Program Expansion: The Department of Health and Human Services (DHHS) has estimated that the appropriation included in the proposed legislation can expand the Community Care of North Carolina Program by supporting the addition of 170,000 eligible Medicaid recipients. This fiscal note assumes that the number of Medicaid recipients served under the proposed legislation will increase each year at the same rate as the State's overall population.

State Fiscal Year	State Population Growth Rate	Community Care Expansion
2004-05	na	170,000
2005-06	1.73%	172,933
2006-07	1.70%	175,917
2007-08	1.67%	178,900
2008-09	1.64%	181,884

The State population growth rate was determined using the State Population Estimates for 2003 – 2010 developed by the State Demographer.

B. Cost Estimated for the Program Expansion: Under the Community Care of North Carolina Program, physician care managers are paid based on the number of Medicaid recipients that they agree to case manage while also providing primary medical care services. For their services, physician care managers are paid $4.00 per Medicaid recipient per month or $48 per year. This fiscal note estimates the cost of paying the management fee by multiplying $48 times the estimated number of Medicaid recipients served during each state fiscal year.

DHHS is also proposing to start a performance based provider incentive program that will help support the start-up cost for new physician practices in the community Care of North Carolina Program and provide performance based incentives for all physicians participating in the program. DHHS has estimated that the provider incentives will cost $1,839,955 during SFY 2004-05 and $935,820 for SFY 2005-06. This fiscal note assumes that the cost for provider incentives for state fiscal years 2006-07 through 2008-09 will growth at the same growth rate as the state population.

State Fiscal Year	Management Fee	Provider Incentives	Total Expenditures
2004-05	$8,160,045	$1,839,955	$10,000,000
2005-06	$8,300,784	$935,820	$9,236,604
2006-07	$8,443,996	$951,691	$9,395,687
2007-08	$8,587,199	$967,563	$9,554,762
2008-09	$8,730,416	$983,434	$9,713,850

C. Determination of State, County, and Federal Participation for Program Expansion: Since the Community Care of North Carolina Program is operated by the Division of Medical Assistance, the financing of the program expansion will be a combination of State, federal and county funding. The Federal Financial Participation (FFP) Rate determines the federal share of the Medicaid program. The rate is based on the relationship between each state's per capita personal income and that of the nation as a whole. The FFP is calculated annually and the rate changes each year. Under state law, county governments pay 15% on the nonfederal share of the North Carolina Medicaid program and the state pays the rest of the nonfederal share. The chart below shows the estimated rate of financial participation for the State, counties, and the federal government. The Division of Medical Assistance develops estimated participation rates annually when it updates its Medicaid forecast model.

State Fiscal Year	Federal Share	State Share	County Share
2004-05	63.44%	31.08%	5.48%
2005-06	63.43%	31.08%	5.49%
2006-07	63.17%	31.31%	5.52%
2007-08	62.92%	31.52%	5.56%
2008-09	62.67%	31.73%	5.60%

SOURCES OF DATA:

Department of Health and Human Services
State Demographer

TECHNICAL CONSIDERATIONS: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **D**

BILL DRAFT 2003-LNz-138 [v.6] (3/22)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/14/2004 12:08:50 PM

Short Title:	DHHS Disease Mgmt Activities.	(Public)
Sponsors:	Representative.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INITIATE OR CONTINUE CERTAIN DISEASE MANAGEMENT ACTIVITIES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE .

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall take action to address the rising cost of health care provided under the State Medical Assistance Plan as follows:

(1) Adopt contractual agreements with providers of services that require and reward use of evidence-based practice standards and guidelines for Medicaid and NC Health Choice.

(2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall

a. Ensure collaboration between local management entities providing mental health services and Community Care of North Carolina providers that serve Medicaid enrollees diagnosed with depression, and

b. Require evidence-based practices for the treatment of psychotic illnesses.

(3) The Secretary of Health and Human Services shall consider developing a program of supplemental rebates for improvements to the Medicaid program.

(4) The Division of Medical Assistance shall consider the following as it develops plans to improve the quality, utilization, and cost-effectiveness of the Medicaid Program:

a. New disease management initiatives that target such costly diseases or conditions as congestive heart failure, chronic lung disease, chronic kidney disease, sickle cell disease, and low birth weight.
b. Collaborate with the Division of Public Health and other community organizations to improve the coordination and implementation of key initiatives to address obesity, premature birth, and smoking cessation.
c. Collaborate with local management entities that provide mental health services to develop local systems and processes that enhance the ability of primary care physicians to care for non-targeted mental illness and substance abuse clients.
d. Use case management processes to improve the utilization and access to such community-based services as ancillary and in-home support services.
e. Investigate the use of incentives or technology to promote the effective use of evidence-based guidelines by Program participants.

The Department shall report on the progress of these activities to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services not later than March 1, 2005.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **D**

BILL DRAFT 2003-LNz-141 [v.5] (3/22)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/26/2004 11:58:38 AM

Short Title:	Disease Mgmt Activities State Health Plan.	(Public)
Sponsors:	Representative.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE EXECUTIVE ADMINISTRATOR OF THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO INITIATE OR CONTINUE CERTAIN DISEASE MANAGEMENT ACTIVITIES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. The Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan shall do the following to address the rising cost of health care covered under the Plan:

(1) Develop a program to more effectively publicize and promote disease management activities to Plan members.

(2) Enhance current efforts to manage diseases, claims, and usage by high-risk and potential high-risk Plan members.

(3) Develop incentives to encourage participation by providers of health care services and Plan members in disease management programs. These incentives may include:

a. Offering additional or enhanced benefits under the Plan to those who participate in disease management.

b. Offering incentives to providers in the form of case management fees or additional service payments.

c. Reward providers that meet nationally recognized quality of care guidelines.

(4) Ensure that the Plan's disease management activities include adequate technological capabilities to identify high-cost and potential high-cost patients, manage comorbidities, and enhance communication between patients and providers.

(5) Publicize performance measures that are linked to standardized health status indicators and use the performance measures to justify enhanced reimbursements to providers and to target State resources for enhancing the Plan's reimbursements to providers of health care services.

(6) Adopt contractual agreements with providers that require and reward evidence-based practice standards and guidelines for the Plan and for NC Health Choice.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

BILL DRAFT 2003-LNz-134 [v.17] (2/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/29/2004 11:00:41 AM

Short Title:	Health Insurance Innovations Commission.	(Public)
Sponsors:	Representative C. Wilson.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE INNOVATIONS COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. Findings and purpose. The General Assembly finds that a crisis exists in the availability and affordability of adequate health insurance coverage for small business owners and employees in this State. These findings indicate that greater than fifty percent (50%) of the statewide workforce is employed by small business, that there are one million one hundred fifty-four thousand (1,154,000) North Carolinians who are not covered by health insurance and that more than sixty percent (60%) of these citizens either own or work for a small business, or are the dependent of a small business owner or employee. The findings further indicate that 16 health insurance carriers left the North Carolina small group health coverage market in 2001, an all-time high, that virtually no small group health insurance carriers have entered the North Carolina market in the last two years, and that dramatic increases in premium rates is the primary reason for the alarming decrease in availability of health insurance coverage for small business. The purpose of this Act is to quickly and effectively address this crisis through the collaborative efforts of persons involved in and affected by the declining availability of health insurance for the State's small employer workforce. It is the intent of the General Assembly to achieve this purpose through the establishment of the North Carolina Health Insurance Innovations Commission in accordance with this Act.

SECTION 2. Commission established. There is established the North Carolina Health Insurance Innovations Commission. The Commission shall consist of 24 members, appointed as follows:

(1) Twelve members appointed by the General Assembly, six upon the recommendation of each of the Speakers of the House of

Representatives. Upon appointment each speaker shall designate a co-chair.

(2) Twelve members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate. Upon appointment the President Pro Tempore shall designate a co-chair.

The appointing authorities shall ensure that members of the Commission are representative of the following: three who represent health insurers, three physicians licensed to practice in this State, three who represent hospitals located in this State, two who represent businesses with fewer than fifty employees and two who represent businesses with fifty employees or more. The appointing authorities shall also ensure that appointments reflect representation among the regions of the State.

SECTION 3.(a) Commission duties and responsibilities. The Commission shall do the following:

(1) Adopt procedures and implement other administrative requirements necessary to carry out its duties under this act.

(2) Identify and evaluate comprehensively the problems small employers face when they attempt to obtain health insurance coverage for themselves and their employees, and consider the impact these problems have for large employees and the communities they serve.

(3) Initiate regional demonstration projects to pilot innovative health care plans and products to address the problems identified. Innovative products may include piloted community education programs targeted at top illnesses in an effort to increase early detection of these illnesses. Innovative plans and products are subject to the approval of the Commissioner of Insurance as provided in Section 5 of this act.

(4) Develop clear and substantive recommendations for actions that must be taken by health insurance carriers, health care providers, government, small business employers, large business employers, consumers and consumer groups, in order to improve the availability and affordability of small employer health insurance coverage within the next three years.

(5) Provide a report on the Commission's activities to the 2005 General Assembly, Regular Session 2006, upon its convening. Reports to the General Assembly shall include proposed legislation necessary to carry out the purposes of this Act.

SECTION 3.(b) The Commission shall consider the following issues and strategies in developing regional demonstration projects and other approaches to address the rising cost of health care:

(1) Feasibility of establishing chronic disease management programs similar to those that are working successfully in this State and other states.

(2) The cost-effectiveness of existing and proposed health insurance coverage mandates.

(3) Promoting collaboration among providers, insurers, government agencies, and consumers to improve health care affordability.
(4) Promoting consumer education about available insurance products.
(5) Review and evaluate "consumer driven" benefit plans.
(6) Increasing efforts and resources to educate and motivate consumers to use health care resources appropriately.
(7) Rewarding technological innovation based in quality and evidence-based outcomes that provide increased value to consumers over existing treatments.
(8) Encourage case management of high utilizers.
(9) Promoting evidence-based medicine.

SECTION 4. Meetings; staff; funding. Members shall serve an initial 2-year term and may be reappointed for an additional 2-year term. The Commission shall secure federal or private funds to conduct meetings, hire professional staff, support demonstration plans and products, and cover any other costs incurred by the Commission in carrying out its duties under this Act. The Department of Insurance shall, at the request of the Commission, provide technical assistance in the preparation of grant proposals for federal and other non-State funding to support the work of the Commission, in the preparation of forms, and in other related matters. The Commission may meet in the Legislative Building or the Legislative Office Building, as approved by the Legislative Services Commission, or at any other location deemed appropriate by the Health Insurance Innovations Commission. The Commission may enter into agreements and allocate federal or private funds obtained by the Commission with the University of North Carolina – Charlotte and other public or private entities to provide meeting space, professional services and support staff, and other services necessary for the Commission to carry out is duties and responsibilities under this act.

SECTION 5. Waiver of rules. The Commissioner of Insurance shall review all pilot programs and innovative plans and products proposed by the North Carolina Health Insurance Innovations Commission. If the Commissioner determines that the proposed programs, plans, or products are in the interest of the citizens of this State and are not contrary to the public policy of this State, then the Commissioner may approve them. If the approved programs, plans, or products are in conflict with or contrary to rules adopted by the Commissioner, the Commissioner may waive the rules adopted by the Commissioner to allow implementation of the programs, plans, or products. Waivers granted by the Commissioner under this section shall expire three years from the date the waiver is granted or December 31, 2008, whichever occurs first.

SECTION 6. Funds obtained by the North Carolina Health Innovations Commission for operations and programs of the Commission shall be deposited with the State Treasurer for credit to the Legislative Services Office. The Legislative Services Office shall allocate these funds for reimbursement to the Commission for operation and program costs incurred.

SECTION 7. Nothing in this act obligates the General Assembly to appropriate funds to implement this act. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **D**

BILL DRAFT 2003-LNz-137 [v.4] (3/22)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/29/2004 2:00:15 PM

Short Title: High-Risk Health Insurance Study. (Public)

Sponsors: Representative Insko.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE STUDY COMMITTEE ON HIGH-RISK HEALTH INSURANCE POOLS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is established the Study Committee on High-Risk Health Insurance Pools. The Committee shall study the establishment of a high-risk health insurance pool regulated by the State in order to make health insurance available and affordable to individuals who have been denied health insurance coverage due to a high-risk health condition. In conducting the study, the Committee shall examine in-depth, the following:

(1) Key issues relating to regulatory oversight of the high-risk pool.

(2) Funding sources and methods for start-up expenses of the high-risk pool.

(3) Pricing and eligibility for high-risk pool coverage.

(4) Financing mechanisms that assure ongoing high-risk pool solvency and affordability of coverage.

(5) Terms and provisions of high-risk pool coverage.

(6) The benefits and limitations of high-risk pools in operation in other states.

(7) The impact of a high-risk pool on the operations of health insurance companies resulting from potential risk shifting of the most expensive policyholders to other insuring entities.

SECTION 1.(b) The Study Committee on High-Risk Health Insurance Pools shall consist of 15 members, appointed as follows:

(1) Six appointed by the General Assembly upon the recommendations of the Speakers of the House of Representatives.

(2) Six appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate.
(3) Two appointed by the Governor.
(4) The Commissioner of Insurance, or his designee, shall serve ex-officio.

Members shall serve for 2 year terms and may be reappointed for one additional term. Vacancies in membership shall be filled by the original appointing authority. The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. the Committee may contract for professional, clerical, or consultant services as provided by G.S. 120-32.02.

SECTION 1.(c) Subject to the approval of the Legislative Services Commission, the Committee may meet in the Legislative Building or the Legislative Office Building. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. The House of Representatives' and the Senate's Supervisors of clerks shall assign clerical support staff to the Committee, and the expenses relating to clerical employees shall be borne by the Committee. Members of the Committee shall receive subsistence and travel expenses at the rates set forth in G.S. 120-3.1, 138-5, or 138-6, as appropriate.

SECTION 1.(d) The Committee shall report to the 2005 General Assembly upon its convening, and shall make its final report to the 2006 Regular Session of the 2005 General Assembly upon its convening. Progress and final reports of the Commission may include recommended legislation. The Committee shall terminate upon the convening of the 2006 Regular Session of the 2005 General Assembly.

SECTION 2. Of the funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Committee established by this act.

SECTION 3. This act is effective upon ratification.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-LYxz-135 [v.5] (1/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
2/2/2004 11:38:36 AM

Short Title: IRC Update. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE REFERENCE TO THE INTERNAL REVENUE CODE USED IN DEFINING AND DETERMINING CERTAIN STATE TAX PROVISIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 105-228.90(b)(1b) reads as rewritten:

"(b) Definitions. – The following definitions apply in this Article:

...

(1b) Code. – The Internal Revenue Code as enacted as of ~~June 1, 2003,~~January 1, 2004, including any provisions enacted as of that date which become effective either before or after that date."

SECTION 2. Notwithstanding Section 1 of this bill, any amendments to the Internal Revenue Code enacted after June 1, 2003, that increase North Carolina taxable income for the 2003 taxable year become effective for taxable years beginning on or after January 1, 2004.

SECTION 3. Notwithstanding the time limitations of G.S. 105-266 and G.S. 105-266.1, a refund for an overpayment of tax resulting from a change in the law enacted by this act regarding the exclusion of gain on the sale or exchange of a principal residence by a member of the uniformed services or the Foreign Service of the United States is timely if a demand for the refund is filed on or before December 31, 2004.

SECTION 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **D**

BILL DRAFT 2003-SWz-28 [v.7] (3/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/24/2004 4:30:40 PM

Short Title:	Study Committee on Health Care Workforce Dev.	(Public)
Sponsors:	Representative.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE HEALTH CARE WORKFORCE DEVELOPMENT STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. There is created the Health Care Workforce Study Commission ("Commission"). The Commission shall consist of 16 members appointed as follows:

(1) Four members appointed by the Governor, to include:
- a. One person who is a health care provider or a pharmacist in a rural community.
- b. One person who is a hospital administrator from recommendations provided by the North Carolina Hospital Association.
- c. One person who is a dental care provider.
- d. One person from the Office of Research, Demonstrations, and Rural Health Development of the Department of Health and Human Services.

(2) Six members appointed by the Speakers of the House of Representatives, to include:
- a. Four members of the House of Representatives.
- b. One person who is a nursing home administrator from recommendations provided by the NC Health Care Facilities Association.
- c. One person who is a community college president from recommendations provided by President of the Community Colleges.

(3) Six members appointed by the President Pro Tempore of the Senate, to include:
a. Four members of the Senate.
b. One person who operates an adult care home from recommendations provided by the NC Association of Long Term Care Facilities.
c. One person who is a university president from recommendations provided by the President of the UNC system.

SECTION 2. The purpose of the Commission is to determine how to increase the number of people available to provide health and dental care in this State. In undertaking this study, the Commission shall consider the following:

(1) How to cultivate an interest in health occupations programs at the secondary school level.
(2) How to address the shortage of adequately prepared health care occupations faculty at community colleges, including designating health care occupation degrees as "high cost" programs and paying health care occupation faculty at a higher rate, designating a salary differential for faculty members who provide clinical or classroom training during evening, night and weekend shifts, and offering other incentives to encourage Masters trained professionals to teach at community colleges.
(3) How to address the attrition rates for students in health care occupation curriculums in community colleges.
(4) Resources available to assist community colleges with the purchase of equipment necessary to train students for health care occupations.
(5) Shortages of faculty at the university level.
(6) Restoring funding for university level Fast Track programs.
(7) Whether a curriculum program that offers a baccalaureate degree in respiratory therapy should be established in the UNC system.
(8) How to improve current programs responsible for addressing dentist and physician shortages, particularly in the rural parts of the State.
(9) How to address nursing shortages, taking into consideration the Institute of Medicine's Nursing Task Force recommendations.
(10) How to address shortages of pharmacists.

SECTION 3. The Speakers of the House of Representatives shall appoint a cochair, and the President Pro Tempore of the Senate shall appoint a cochair for the Commission. The Commission may contract for consultant services as provided by G.S. 120-32.02. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional and clerical staff to assist in the work of the Commission. Clerical staff shall be furnished to the Commission through the offices of the House of Representatives and Senate Supervisors of Clerks. The Commission may meet in the Legislative Building or the Legislative Office Building upon the approval of the Legislative Services Commission. The Commission, while in discharge of official

duties, may exercise all the powers provided under the provisions of G.S. 120-19 through G.S. 120-19.4, including the power to request all officers, agents, agencies, and departments of the State to provide any information, data, or documents within their possession, ascertainable from their records, or otherwise available to them, and the power to subpoena witnesses. Members of the Commission shall receive per diem, subsistence, and travel allowances at the rate established in G.S. 120-3.1, 138-5, or 138-6, as appropriate. Vacancies shall be filled by the appointing authority.

SECTION 4. The Commission shall submit an interim report to the 2005 Regular Session of the 2005 General Assembly that contains its recommendations, legislative proposals, and cost analyses. The Commission shall make a final report to the 2006 Regular Session of the 2005 General Assembly and shall terminate upon the earlier of the filing of its final report or April 30, 2006.

SECTION 5. From the funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Commission established in this act.

SECTION 6. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **D**

BILL DRAFT 2003-LNz-139 [v.6] (3/22)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/26/2004 11:55:16 AM

Short Title: LRC Study Health Insurance Mandates. (Public)

Sponsors: Representative.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE MORATORIUM ON HEALTH INSURANCE MANDATES TO JULY 1, 2006, AND TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY HEALTH INSURANCE MANDATES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. Section 3 of S.L. 2001-453 reads as rewritten:

'**SECTION 3.** This act is effective when it becomes law. Section 1 of this act expires July 1, ~~2005.~~2006.'

SECTION 2. The Legislative Research Commission may study the issue of health insurance mandated benefits and the cost to employers and individuals of unfunded health insurance mandates. In conducting the study, the Commission shall consider cost-benefit analysis to determine the cost-efficiency of mandated benefits, including any cost-benefit analysis performed by the Department of Insurance. In conducting the study the Commission shall consider how health insurance mandates improve patient care, how mandated preventive health services may be cost effective through early detection and treatment of disease, and whether health insurance mandates disproportionately impact small business through increased premium costs. The Commission shall make a progress report to the 2005 General Assembly upon its convening, and shall make its final report to the 2005 General Assembly upon its reconvening. Progress and final reports of the Commission may include recommended legislation.

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SWz-30 [v.4] (3/22)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/24/2004 4:32:19 PM

Short Title: Repeal Sunset/Long Term Care Ins. Tax Credit. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE SUNSET ON THE LONG TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. Section 29A.6(d) of Chapter 212 of the 1998 Session Laws reads as rewritten:

"(d) Subsection (a) of this section is effective for taxable years beginning on or after ~~January 1, 1999, and expires for taxable years beginning on or after January 1, 2004.~~January 1, 1999. The remainder of this section is effective when it becomes law. ~~G.S. 105-160.3(b)(7), as enacted by this act, is repealed effective for taxable years beginning on or after January 1, 2004.~~"

SECTION 2. This act is effective for taxable years beginning on or after January 1, 2004.